Administrative Code

Title 23: Medicaid
Part 205

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Rule 1.1: General

A. For purposes of this rule a hospice shall be defined as a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals.

B. Treatment shall be palliative or management of a terminal illness, except for children under age twenty one (21). Medicaid defines palliative as the relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

C. Terminal illness is defined as an illness with a medical prognosis of life expectancy of six (6) months or less.

D. Beneficiaries may not be enrolled in a home and community-based waiver and receive hospice services simultaneously.

Source: Miss. Code Ann. § 43-13-121; 41-85-1 – §41-85-25 (1972, as amended); Title 18, Section 1861 (dd) of the Social Security Act; Section 2302 of the Patient Protection and Affordable Care Act of 2010

Rule 1.2: Provider Enrollment Requirements

Providers of hospice must meet the following criteria:

A. Meet the conditions of participation set forth in 42 CFR, Chapter IV Centers for Medicare & Medicaid Services, Department of Health and Human Services, Part 418, and

B. Be licensed and certified for participation by the State survey agency, Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification (HFLC), and

C. Enter into a provider agreement with the Mississippi Division of Medicaid (DOM).

D. Hospice providers applying for enrollment as Medicaid providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

    1. National Provider Identifier (NPI), verification from National Plan and Provider

Enumeration System (NPPES)

2. Written confirmation from the IRS confirming your tax identification number and legal business name.

3. Copy of current Medicare certification or Tie-In Notice

4. EOMB is not acceptable and must be from Medicare Intermediary

5. Copy of current license or certification letter and must be from state of servicing location

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Physician Certification/Re-Certification

A. Admission to hospice and subsequent re-enrollment periods must be certified through the Division of Medicaid Utilization Management and Quality Improvement Organization. All certification/recertification requirements under CFR 42, Part 418 must be met except as otherwise noted below:

1. Initial Certification to Hospice

a) The written initial certification statement must be signed by the medical director of the hospice OR the physician member of the hospice interdisciplinary group, AND the beneficiary's attending physician. The written certification must include a statement that the beneficiary's medical prognosis is six (6) months or less, and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

b) The attending physician must be a doctor of medicine or osteopathy and must be identified by the individual at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

c) The medical director of the hospice or physician member of the hospice interdisciplinary group and the beneficiary's attending/certifying physician MUST be different physicians. Medical certification is required by the individual's attending physician; however, if the beneficiary's primary attending physician and the hospice interdisciplinary physician or the hospice medical director is the same person, the documentation must be provided to show that this person has been treating the beneficiary for the end of life illness prior to admission.

2. The written re-certification statement must be signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group. The written

certification must include a statement that the beneficiary's medical prognosis is six (6) months or less and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

B. The physician signing the written certification/re-certification statement can be held liable for causing false claims to be submitted. A written certification must be obtained before billing for hospice services.

C. The hospice must retain the certification/re-certification statement in the beneficiary's medical record. This must be maintained at the hospice site issued the provider license and DOM provider number.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Election, Enrollment, and Revocation

A. Medicaid shall reimburse the hospice provider when the beneficiary/legal representative elects to receive the palliative care of the hospice services rather than active treatment of the terminal condition.

B. Eligibility to elect hospice care under Medicaid requires:

1. Certification of the beneficiary as being terminally ill with a life expectancy of six (6) months or less, and

2. Documentation of a diagnosis consistent with a terminal stage of six (6) months or less.

3. Completion of an Election Package

C. The hospice benefit is divided into distinct periods, which stand alone and once used is no longer available. The maximum number of days in each election period is as follows:

1. 1st – ninety (90) days

2. 2nd – ninety (90) days

3. 3rd – sixty (60) days - unlimited increments

D. The election to receive hospice care is considered continuous for each election period as long as the beneficiary remains under the care of the hospice program, does not revoke the election, and continues to meet Medicaid eligibility requirements.

E. Election of Hospice option causes the beneficiary to forfeit all other Medicaid program benefits provided for in the State Plan that may also be available under the hospice benefit related to treatment of the individual terminal illness, except for children under the age of twenty-one (21).

F. Change in hospice designations can be made once per election period and is not considered a revocation of the election.

G. Election of hospice care can be revoked at any time by the beneficiary/legal representative. Disenrollment from hospice is required for, but not limited to, the following:

1. Death

2. Hospitalization unrelated to terminal illness

3. Beneficiary is seeking treatment other than palliative in nature

4. Beneficiary no longer meets program requirements

H. Medicaid will not reimburse for the date of discharge, transfer or the date of death.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: Election of Hospice Care

A. The beneficiary must waive all rights to Medicaid payments for the duration of the election of hospice care for the following services:

1. Hospice care provided by a hospice other than the hospice designated by the beneficiary/legal representative (unless provided under arrangements made by the designated hospice), and

2. Any Medicaid services that are related to the treatment of the terminal condition or a related condition for which hospice care was elected or that are equivalent to hospice care except:

a) Services provided (either directly or under arrangement) by the designated hospice.

b) Services provided by the beneficiary's attending physician, if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

c) Services provided as room, board, and services by a nursing facility if the beneficiary is a resident at the time the hospice election is made and Medicaid was paying for that service.

B. Waiver of Medicaid services ceases and all Medicaid benefits to the limits permitted, are available at the completion of a hospice benefit period or at the revocation of remaining days.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Covered Services

A. Covered services provided through hospice include core hospice services such as physician services, nursing care, medical social services, and counseling services in addition to special coverage services such as continued home care, respite care, bereavement counseling and general inpatient care. All personnel must meet applicable state and federal licensing/certification requirements.

B. Core Services

1. Physician services must be performed by a physician as defined in 42 CFR 418. Exception are the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy).

2. Nursing care must be provided by a registered nurse (RN).

3. Medical social services must be provided by a licensed social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

4. Counseling services with respect to the care of the terminally ill individual and adjustment to death shall be provided to the terminally ill beneficiary and the family members or other persons caring for the beneficiary at home.

5. Medical appliances and supplies, drugs, and biologicals.

6. Hospice aide services must be furnished by qualified aides and homemaker services.

7. Physical therapy, occupational therapy, and speech-language pathology services.

8. Providers and practitioners who furnish hospice services must meet all requirements in accordance with the rules and regulations as defined in the Minimum Standards of Operation for Hospice per the Mississippi State Department of Health.

C. Continuous Home Care shall be provided only during a period of crisis.

1. The hospice must provide a minimum of eight (8) hours of care by a Registered Nurse (RN) during a twenty-four (24) hour day that begins and ends at midnight.

2. Continuous home care may not be provided when the hospice beneficiary is a nursing home resident or an inpatient of a free-standing hospice.

D. Respite Care

1. Respite care shall be provided to relieve family members or other persons caring for the

beneficiary at home and shall not be reimbursed for more than five (5) consecutive days at a time.

2. Respite care shall not be provided when the hospice beneficiary is a nursing home resident is an inpatient of a free-standing hospice, or the services are a duplication of any other like services being delivered to the beneficiary.

E. Bereavement Counseling shall be provided to the beneficiary's family after the beneficiary's death up to twelve (12) months.

F. General/Short-term Inpatient Care shall be provided in a participating hospice inpatient unit, hospital, or a participating SNF or NF that additionally meets the special hospice standards regarding patient and staffing areas. Short term inpatient care includes both Respite care and procedures necessary for pain control and acute system management.

Source: Miss. Code Ann. § 43-13-121; §41-85-1 through 41-85-25(1972, as amended)

Rule 1.7: Transportation

A. The provider shall provide:

1. Transportation for medical services relating to the terminal illness must be provided and paid for by the hospice provider.

2. Transportation from the hospital to the beneficiary's residence or to a freestanding hospice facility during a period of hospitalization after election of the hospice benefit.

B. Transportation shall be non-covered when:

1. The hospice beneficiary calls 911 for ambulance/medical assistance,

2. The hospice beneficiary requests transportation for services that are not palliative in nature. The hospice provider must arrange non-emergency transportation through the Medicaid non-emergency transportation program. (Part 201, Chapter 2)

3. The hospice beneficiary requires or seeks transportation for medical services unrelated to the terminal illness.

Source: Miss. Code Ann. § 43-13-121

Rule 1.8: Reimbursement

A. Medicaid reimbursement for hospice care is made at one of four (4) predetermined rates for each day that the beneficiary is under the care of the hospice with the exception of payment for attending physician services.

1. Routine Home Care- Medicaid shall reimburse the hospice the routine home care rate for each day the beneficiary is under the care of the hospice. The rate will be reimbursed without regard to the volume or intensity of services provided on any given day if a beneficiary is a nursing facility resident.

2. Continuous Home Care- Medicaid shall reimburse the hospice an hourly rate for continuous home care which includes a minimum of eight (8) hours of care rendered by a registered nurse. Every hour or part of an hour of continuous care will be reimbursed at the hourly rate up to twenty-four 24) hours per day. The rate is not payable when the hospice beneficiary is a resident of a nursing facility or an inpatient of a free-standing hospice.

3. Inpatient Respite Care- Medicaid shall reimburse the hospice an inpatient respite care rate for each day the beneficiary stays in an approved inpatient respite facility. Inpatient respite care is limited to a maximum of five (5) consecutive days at a time. This rate is not payable when the hospice beneficiary is a resident of a nursing facility or an inpatient of a free-standing hospice.

4. General Inpatient Care- Medicaid shall reimburse the hospice at the general inpatient care rate for each day such care is consistent with the patient's plan of care.

B. Medicaid shall reimburse the hospice for **r**espite and general inpatient days. The hospice must reimburse the facility that provides inpatient care.

C. Medicaid will not reimburse for the date of discharge or the date of death.

D. Medicaid does not reimburse the hospice separately for hospice physician services, except for coinsurance payments that result from Medicare approved claims. Medicaid will pay the claims of attending physicians for direct patient care services to beneficiaries that elect the hospice option as long as such services are not routinely provided to the hospice's patients on a voluntary basis.

E. Reimbursement for Beneficiaries in a Nursing Facility

1. DOM does not reimburse the hospice provider for nursing facility bed-hold days.

2. Room and board shall be reimbursed to the hospital at 95% of the nursing home's established Medicaid per diem.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Documentation Requirements

A. Hospice medical records must be maintained at the hospice site issued the provider license and provider number by DOM. Each record must contain the following for each beneficiary:

1. The Election Package

2. The original Disenrollment/Transfer Form (Form 1166) signed by the beneficiary/legal representative and the hospice provider, as required;

3. An interdisciplinary Plan of Care that supports each hospice service rendered including needs, care, services and goals;

4. Treatment rendered including:

   a) Each discipline's visit or contact of the treatment or intervention rendered at the frequency ordered on the plan of care.

   b) Documentation to show relationship of the treatment plan and medications to the terminal.

   c) Illness.

   d) Provider's signature or initials on all medical records.

5. An auditable medication list that is updated monthly and clearly indicates the medications the hospice paid related to the terminal illness. This list shall contain the name and address of the pharmacy that was paid. The medical record must include a medication list for each month of certification that clearly indicates which medications are being paid by the hospice.

6. A monthly updated list of medical appliances and supplies related to the terminal illness paid for by the hospice; and the names and address(s) of the providers paid.

B. Documentation must be maintained in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121

Rule 1.10: Dual Eligibles

The hospice benefit shall be used simultaneously under Medicare and Medicaid with Medicare providing primary coverage for dual eligible beneficiaries. The hospice benefit, and each period therein, is available only once in a lifetime for dual eligible beneficiaries.

Source: Miss. Code Ann. § 43-13-121